



BMUS Recommended Audit Tool – Explanatory Notes

To be used in conjunction with the BMUS Recommended Peer Review Audit Tool

Introduction

There is an increasing need for peer review to be undertaken within clinical ultrasound departments. There is much evidence available to support this and many tools have been described ^(1,2). However, finding an audit tool that is suitable for the dynamic and operator dependent imaging modality of ultrasound can be difficult.

The hard copy images and written report are the only recorded evidence of the examination. The quality of these two factors can be measured. In addition, the clinical quality of the examination can also be recorded. The BMUS recommended peer review audit tool gives users a reproducible mechanism with which all these quality factors can be measured reliably and repeatedly.

Development

The BMUS recommended audit tool has been developed from various peer review tools available. This tool has been tested by a group of ultrasound experts who form the BMUS Professional Standards Group.

Using this tool within a service will measure the standard of imaging, reporting and clinical quality being recorded; but clearly will not provide comment on what is not. The tool is designed to be used by individuals to review their own and their peers' practice. Therefore, it is acknowledged that the standard being reviewed will be measured by a service's own rather than a national standard.

In line with recent Royal College of Radiologists Standard publications it is strongly recommended that this peer review audit is undertaken in conjunction with a discrepancy meeting. It is recommended that each service agrees a tolerance level of acceptable quality and any cases falling below this tolerance level should be discussed openly within a discrepancy meeting and learning points and further action agreed within the team of peers. (3,4)

Recommendations for Use

It is acknowledged that a peer review of images and reports takes time. A reasonable estimation of time required is to allocate an average of 5 mins per case reviewed. It is recommended that services should aim for a review of 5% of all examinations and reports. (3,4)



A timely retrospective audit of cases is required. Services may wish to allocate time on a daily, weekly or monthly basis. Access to image and report storage facilities are required and often assistance from IT departments or PACS system managers is required to retrieve retrospective data of examinations performed.

A randomised sample of examinations will reduce bias between reviewers and users of this tool are advised to determine a reliable method to both retrieve data and ensure it is randomised. Some users may prefer that the cases are anonymous but this can be detrimental to the service being able to identify learning needs of individual practitioners.

Individual services will need to agree who within the team is to perform reviews bearing in mind that inclusion into audit process systems often improves compliance with them and enhances a sense of ownership and responsibility. It is strongly suggested that all practitioners within a team participate in the process.

A database for identifying cases that have been reviewed and storing the audit data will need to be established. This can be an electronic database, a system linked to hospital patient records or a paper filing system. Services need to be mindful of data protection and information governance guidance and legislation with regards storing patient data.

Review Process

Once cases for review have been identified the reviewer will need to access the referral information, the stored images and the issued report.

All three aspects of the examination are reviewed.

Initially the clinical question should be reviewed. Is it clear and appropriate?

The images are then reviewed and categorised into good, acceptable or poor. These judgements will be based on the reviewer's own standard of practice.

The report will then be reviewed and again categorised into good, acceptable or poor. BMUS recommended reporting standards and best practice is documented in the following article ⁽⁵⁾ available from the Ultrasound journal and which can also be found via the BMUS website

Finally, the reviewer should determine if the clinical question has been answered and whether appropriate advice or a conclusion has been given where appropriate. This can include a statement of normality or "no cause of symptoms demonstrated" and may be dictated by department practice. It is recognised that in some specialised cases, or cases including intervention, a conclusion may not be desirable or helpful.



All scores should be recorded on an appropriate database. It is recommended that cases falling below the departments predetermined minimum standards level are discussed with the individual practitioner before being discussed openly at a discrepancy meeting. It is strongly recommended that any significant errors, such as unreported pathology or significant typographical errors are rectified immediately by issuing either a supplementary report or recalling the patient following discussion with the practitioner and / or clinician referring the examination.

Future Developments

BMUS aims to continue to develop tools to support good practice. A series of images appropriate to the scoring system against which services and individuals can benchmark themselves will be developed.

In addition the professional standards group is developing a document to support the justification of accepting appropriate referrals; and support rejecting the more inappropriate and vague referrals often received.

References:

1. Fitzgerald, R. (2005) Radiological error, analysis, standard setting, targeted instruction and team working. *European Radiology*. **15**, pp.1760-1767.
2. The Royal College of Radiologists. (2001). To err is human: the case for review of reporting discrepancies. London: *The Royal College of Radiologists*.
3. The Royal College of Radiologists. (2014) Quality assurance in radiology reporting: peer feedback. London: *The Royal College of Radiologists*.
4. The Royal College of Radiologists. (2014) Standards for Learning from Discrepancy Meeting. London: *The Royal College of Radiologists*.
5. Edwards, H et al (2014) What Makes a Good Report? *Ultrasound* **22** pp. 57-60